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United States Government Accountability Office
Washington, DC 20548

April 6, 2007

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

Subject: DOE Health, Safety and Security Office

Dear Mr. Chairman:

Concerning your letter to the Comptroller General requesting a GAO study of the Department of Energy's (DOE) capability to independently ensure nuclear safety across its weapons complex under a new organizational approach to overseeing health, safety and security, we met with your staff on February 23, 2007 and March 23, 2007, to gain a further understanding of your needs.

Because of the complexity of the issue, we need to proceed with a separate design phase. The purpose of this letter is to set forth the study objectives and provide you with a completion date for the design phase. We agreed with your staff that the overall objectives of our work will be to (1) assess how the reorganization has changed nuclear safety oversight at DOE, (2) identify and assess the potential benefits and shortcomings that might arise from this reorganization, and (3) compare DOE's new approach to overseeing nuclear safety with the approaches taken by other domestic and foreign organizations that oversee their externally regulated nuclear facilities.

The design phase will be completed by July 18, 2007. We will remain in contact with your staff, and at the end of the design phase, we will provide you with a projected completion date for the total study. If you should have any questions, please contact me on (202) 512-3841 or my Assistant Director, Daniel Feehan, on (303) 572-7352.

Sincerely yours,

Gene Aloise

Gene Aloise
Director, Natural Resources
and Environment

cc: Richard Miller, Investigator, Subcommittee on Oversight and Investigations

Archive - COGME
cc: J Ford

Russell G. Robertson, M.D.
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COGME
Council on Graduate Medical Education

March 28, 2007

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I wish to share with you the concerns of the Council on Graduate Medical Education (COGME) regarding a rule proposed February 1, 2007 by the Center for Medicare and Medicaid Services. We are sharing this response with others as required by Part H, Section 799 of Title VII of the Public Health Service Act as amended by Public Law 99-272. This rule, CMS-1529-P – LTCH PPS/DGME Proposed Rule: Annual Payment Rates and Policy Changes, proposes a new revised definition of ''all or substantially all'' of the costs of graduate medical education programs at a non-hospital site, which would establish 90 percent threshold and offers a formula for calculating this threshold.

In at least four reports to the Secretary of Health and Human Services and to the Congress, COGME has concurred with Congressional efforts to increase GME training in non-hospital settings without reductions in Medicare GME funding. COGME explicitly warned.

> "A single national policy that allocates funds between hospital and community-based sites using a pre-determined formula does not acknowledge the myriad of existing arrangements for community-based training that could be disrupted." (Fifteenth Report).

Regarding rewards for community clinician teachers, COGME previously recommended,

> "The system of rewards must be clear and related to measures of commitment and quality. The specific form of rewards should be determined by each institution, incorporating input from the community teachers themselves as to what constitutes appropriate "value" in recognition of their efforts and achievements." (Thirteenth Report, March 1999)

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We believe that the Congress had similar intent with passage of the Balanced Budget Amendment of 1997 (BBA97). In the present case, the conference agreement included new permission for hospitals to rotate residents through non-hospital settings, which include primarily ambulatory care settings, without reduction in indirect medical education funds.

COGME expressed concern with the change of definition of "all or substantially all" in calculating the costs of training in the regulations created after the BBA97. In several site visits, COGME noted that the definition change from including only residents' compensation to residents' compensation and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME—was "affecting financial arrangements with community training sites." (Fifteenth Report, December 2000) There is anecdotal evidence that the audits related to this fundamental change are causing reconsideration of training residents outside of hospitals and even frank retrenchment to hospitals. COGME is concerned that the proposed definition would further damage efforts to move training into the settings where most Medicare beneficiaries receive care, and where most future practicing physicians must be prepared to work. Reversing the unintended consequences of the previous definition change has also proven difficult. Bills introduced in the 109th Congress [HR 4403 (Hulshof/Tanner) and S. 2071 (Snowe, Collins, Bingaman, Dorgan)] to revert to the previous definition met stiff resistance due to the considerable cost attributed to the reversal. Once in place, the costs of reversing this new rule and definition will be similarly difficult.

In the proposed rule, CMS acknowledges Congressional intent and states a fundamental belief underpinning the rule: "We further note that the Congress intended to encourage the shift of training to non-hospital settings and we believe this proposed policy change could facilitate further shifts to non-hospital settings." It is our opinion that this belief is flawed and contrary to experience. The proposed rule change will do further damage to an already fragile effort to move resident training and residents' contribution to caring for Medicare beneficiaries into the outpatient setting. This setting-specific rule also has the affect of further harming the primary care training pipeline at a time when the sufficiency of the primary care physician workforce for the Medicare population is already in jeopardy. Lastly, the proposed rule will adversely affect training in rural and underserved settings. Since Medicare beneficiaries locate in rural and underserved areas in higher proportions than the rest of the population, the rule change will work against their interests and those of CMS.

On behalf of COGME, I strongly urge you to reconsider the proposed rule, and to instead consider a return to the definition of "all or substantially all" used prior to 1999.

Similar letters have been sent to the Honorable Edward M. Kennedy, Chairman, Committee on Health, Education, Labor and Pensions, United States Senate, the Honorable Michael O. Leavitt, Secretary of Health and Human Services, and an electronic form of the letter has been submitted to the Centers for Medicare and Medicaid Services.

Sincerely,

Russell Robertson, M.D.
Chair

cc: Elizabeth M. Duke, Administrator
Health Resources and Services Administration

Background and Attachments

Excerpted recommendations from COGME related to non-hospital graduate medical education training

Eleventh Report:
Enhance Primary Care Residency Training

A. Provide Medicare DME payments to a wide variety of ambulatory teaching settings, including managed care plans.

B. Include time spent in ambulatory settings outside the hospital in the calculation of Medicare IME payments to hospitals.

C. Make Medicare IME payments to ambulatory settings outside the hospital when ambulatory cost estimates have been developed.

Practitioner competency is dependent upon training in appropriate settings such as in community-based ambulatory sites. Physicians trained to provide primary care in ambulatory settings can provide comprehensive, continuing, longitudinal care to patients. The policy of providing direct and indirect GME payments only for hospital-based residents or DME payments to residents rotating in hospital based ambulatory clinics has restrained appropriate training for all physicians, generalists in particular, to provide such care. Medicare IME payments to ambulatory settings would provide a strong incentive to initiate such training.

Thirteenth Report:

Medical schools and residency training programs should recruit and support community clinician teachers. Faculty members at community teaching sites should be selected for the quality of their medical practice and the excellence of their teaching. They should be paid and otherwise rewarded for their educational activities. Teaching institutions should develop mechanisms to involve community faculty in the design and operation of educational programs.

The system of rewards must be clear and related to measures of commitment and quality. The specific form of rewards should be determined by each institution, incorporating input from the community teachers themselves as to what constitutes appropriate "value" in recognition of their efforts and achievements.

Fourteenth Report:

Assure adequate funding for training in ambulatory settings. Policies related to financing GME in ambulatory sites should be reviewed closely. If necessary, additional policies and programs should be developed to support quality training in ambulatory settings.

Fifteenth Report:

An individual program may have arrangements for teaching with hospital-based clinics, hospital-operated and hospital-affiliated physician practices, community health centers, and individual clinician-physicians in private practice. The financing arrangements differ for each site depending on a number of factors, including payer mix and the intensity of the teaching effort. The financing issues for hospital-based clinics are quite different than those for community clinics and physician practices. The variety of arrangements suggests that decisions on how GME funds should be allocated among the various participants in a given program are best made at the local level. ***A single national policy that allocates funds between hospital and community-based sites using a pre-determined formula does not acknowledge the myriad of existing arrangements for community-based training that could be disrupted.***

There is some evidence That HCFA's revised definition of "all or substantially all of the costs" of Non-hospital training is affecting financial Arrangements with community training Sites.

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